A Consumer's Guide to:

Health Care Coverage

Understanding Your Health Insurance Options

Washington State
Office of the
Insurance Commissioner

www.insurance.wa.gov

Dear Health Care Consumer:

In the past few years, the face of health care in Washington state (and across the country) has changed dramatically. Many of these changes directly affect your rights and options as a consumer of health insurance and, in some cases, may affect your access to coverage as well as care.

To help you keep up with the constant changes in the health insurance market, understand your rights and options, and obtain health care coverage that meets your needs, my staff has prepared this consumer guide. It will help you understand:

- ✓ what kind of health plan may be best for you and your circumstances;
- ✓ how different types of health care plans work, and;
- ✓ how to obtain quality care and fair treatment from your health care providers.

I cannot emphasize enough how important it is for consumers to have adequate health insurance. Uninsured people may avoid getting treated for medical conditions that can escalate into major health and financial problems.

If you have insurance questions or concerns, call our Insurance Consumer Hotline at 1-800-562-6900. Our professional consumer advocates enforce insurance law and can investigate complaints against insurance companies and agents on your behalf. We also offer individual counseling and group education on health care issues in your communities. Our highly trained SHIBA (Statewide Health Insurance Benefit Advisors) HelpLine volunteers can help you understand your rights and options regarding health care coverage, prescription drugs, governmental programs, and more.

Sincerely,

Mike Kreidler
Washington State Insurance Commissioner

Table of contents

Section 1

Define your needs and eligibility

Health care coverage access issues are complex. You must be sure your health care plan meets your needs.

Different types of health coverage plans are available based on your current needs, personal circumstances, and financial resources. This section will help you discover what kind of policy or plan you may need, are eligible for, and can afford.

You might need to buy health care insurance from the individual market, especially if you don't have insurance through your employer, or a spouse or parent.

Before you buy health insurance, check to see if you qualify for lower cost options. For more information, read Section 3 on "Low cost health coverage options."

Real-life situations in which you may need to buy individual health insurance coverage include:

- ✓ Your employer's health plan does not meet your needs.
- ✓ You haven't worked long enough for your employer to qualify for a plan.
- ✓ You have to wait for an "open-enrollment" period.
- ✓ You just moved to Washington from another state and need insurance.
- ✓ You will no longer qualify for coverage under your parents' policy.
- ✓ The rates for family health insurance through your employer are too costly to cover everyone. If you continue on your employer's plan, you need coverage for your spouse and/or your children.
- ✓ Your kids need insurance to play sports at school.
- ✓ You work one or more part-time jobs, and none offers benefits.

Employment-related coverage

If you are currently employed, you might qualify for the following types of health insurance plans:

Group plans

You may be able to obtain health benefits from an employer for yourself, your spouse, your domestic partner, and your dependents.

If you are enrolling in a group plan, you do not have to take the health screen questionnaire (see page 4). Group plans cannot reject you based on your health. You may also be able to enroll a spouse, domestic partner, and other dependents outside of your employer's plan annual enrollment period. For more information, check with the plan's administrator or your human resource department. If you are self-employed and have at least one full-time employee, you may be eligible for a small group plan.

It's important to recognize that not all employer group plans are the same. If you recently changed plans, be sure to review all of the plan benefit information before you visit the doctor. Be sure you know which doctors you can visit, what is and isn't covered, and how much you will have to pay out-of-pocket.

Professional organizations and association plans

Sometimes professional organizations offer group health plans, such as local realty boards or the chamber of commerce. Association plans are often accessible to people in a specific industry, professional group, or business association. You may also qualify for health insurance through a religious or fraternal organization.

Make sure you fully understand the exact level of benefits you are buying. While association plans are offered statewide, sometimes at very competitive rates, disappointments are common among consumers who were not aware of a plan's limitations and exclusions.

If you choose an association plan, you may want to consider buying riders (additional coverage) to the basic coverage to ensure a more complete package of benefits. It is also important to get benefit information in writing.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA extends health plan benefits to employees who lose medical coverage because they lost their job or had their hours reduced. Most group health plans provided by companies with 20 or more employees are subject to COBRA.

If an employee, spouse, or dependent are covered by the group health plan on the day before a qualifying event, then they may be eligible to continue buying coverage under the group plan for 18-36 months.

A qualifying event for an employee is a reduction in hours or losing a job for reasons other than "gross misconduct."

A qualifying event for a spouse or dependent includes reduction in hours or termination of the employee (as described above), or:

- ✓ **Divorce or legal separation** from the employee
- ✓ **Death** of the employee
- ✓ The employee becomes **eligible for Medicare**
- ✓ **Loss** of "dependent child status"

Individuals who experience a qualifying event should check with the employer to find out if they are eligible for COBRA benefits. A qualified individual must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation, or a child's loss of dependent status under the plan.

Each family member or dependent has the right to elect COBRA coverage.

Enrollees generally pay for COBRA coverage themselves. The COBRA plan administrator may charge up to 102 percent of the total cost of the group plan, which includes the portion previously paid by the employer.

An individual who already has other coverage (including Medicare) on or before the date he or she becomes eligible for COBRA, may continue that coverage along with COBRA coverage. But if the individual qualifies for an employer plan or Medicare after qualifying for COBRA coverage, the employer may terminate the COBRA coverage. However, the employer cannot terminate coverage if the new plan has a preexisting condition clause that applies to the individual.

Not all plans terminate COBRA coverage immediately upon Medicare eligibility, so check with the plan administrator. Generally, dependents are able to continue COBRA coverage even if the primary employee (ex-employee) becomes Medicare-eligible.

Warning: If you are enrolled in Medicare Part A (hospital coverage) and you elect COBRA but fail to enroll in Medicare Part B (medical coverage), you may be subject to Medicare penalties. And it may mean a delay in coverage under Part B when your COBRA expires. This delay could leave you without Medicare Part B coverage for up to 16 months, depending on the date your COBRA expires.

For more information on COBRA, call the U.S. Department of Labor (DOL) Employee Benefits Security Administration at 1-866-444-3272, or check with your employer's human resource office.

Small employer plans (20 or fewer employees) are not required to offer COBRA coverage, but may offer a limited continuation right for terminating employees and their dependents. A plan's benefit booklet should provide details of the continuation benefit.

Coverage for individuals and family

If you need health insurance and are not eligible for Medicare, there are plans available that you can buy.

Most health insurance sold in Washington state operates as either health maintenance organizations (HMOs) or through preferred provider networks.

If you choose an HMO, the plan requires that you obtain all your care from a list of providers (except some emergency care). Your plan may require your primary care doctor to provide a referral before you can see a specialist or go to the hospital.

If you choose a preferred provider network, you pay less if you obtain care from doctors or hospitals that contract with the insurance plan. These providers are referred to as "network" providers. It will cost you more if you go to a doctor or hospital not listed in the plan's network.

Plans may differ greatly from one another. They also may use different copayment systems (an upfront charge the consumer pays for each office visit).

A plan's premium often covers educational and wellness programs, some preventive exams and routine services, and diagnostic services and treatment.

In addition to the premiums, you may have out-of-pocket copayments, deductibles or coinsurance for some services. For services not approved or covered by the plan, you pay the full amount.

Ask about the features of any plan before you enroll and make sure you understand how they work.

Pre-existing condition waiting periods

Individual plans may require a nine-month waiting period for any condition for which you were treated or you would have sought advice or treatment during the previous six months.

If you are switching plans, you may receive credit towards the waiting period for a pre-existing condition. If your prior plan is equal to or better than the new plan, the insurance company must credit your enrollment in that plan toward the waiting period. For example, if you had nine months of coverage under your most recent plan, the insurance company would waive your waiting period. If you had four months coverage, you would have to wait five months for the new insurance to cover a pre-existing condition.

Need more help? Call our toll-free Insurance Consumer Hotline at 1-800-562-6900.

Health screening and the individual market

Application requirements

Most people buying individual health insurance in Washington state will need to complete a standardized health screen questionnaire. If you fail the questionnaire, the insurance company you applied with will automatically send you an application for the Washington State Health Insurance Pool (WSHIP).

Individuals not required to take the health screen

You are not required to fill out the health screen questionnaire when applying for individual insurance if you:

- ✓ will exhaust your COBRA coverage.
- ✓ have 24 months of continuous coverage through a small employer.
- ✓ have moved out of your existing plan's service area within Washington state.
- ✓ are staying with a primary care doctor who left your existing plan.
- ✓ have received a notice about the discontinuation of your conversion plan. This is a limited benefit policy an individual may have a right to convert to after their group insurance ends.

Washington State Health Insurance Pool (WSHIP)

The Washington State Health Insurance Pool (WSHIP) provides health insurance for people who are unable to obtain individual coverage in the private marketplace. This plan provides comprehensive coverage, including a prescription drug benefit. WSHIP bases premiums on age and type of plan selected.

Premiums for WSHIP coverage are higher than commercial health plans. However, WSHIP offers some high deductible plan options with lower premiums.

There are two WSHIP options available for people who are not on Medicare:

- ✓ **The Standard Plan (Plan 1)**, which is fee-for-service, allows you to go to the doctor of your choice.
- ✓ **The Network Plan (Plan 3)** uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (the Basic Plan.) This plan has different eligibility criteria.

WSHIP provides some discount rates to people age 50-64 with low income, people continuously insured with their previous plan, and people who have been in WSHIP for more than three years. For more information about WSHIP, contact the administrator, Benefit Management, Inc., at 1-800-877-5187 or www.wship.org.

Section 2

Shopping for health insurance

This section provides information about how to get the most out of your health insurance coverage. It can also help you decide if the coverage you have is right for you.

Tips: checking out a plan

Make sure the coverage you buy fits your needs, and that you receive the best price for the coverage. You should compare benefits and rates. Look at two or three different plans to compare them against your needs as well as to one another.

Benefits: Make sure you understand the plan's benefits. Look at what the contract **will not cover**, not just what **it will cover**.

Limitations and exclusions: Find out if there are special requirements to obtain benefits. For example: Do you need prior authorization for some services? How do you obtain that authorization? Are there waiting periods before coverage goes into effect?

Claims: Before you buy, make sure you understand how to file a claim, where to send it, and how you will receive payment.

Costs: Premiums for health insurance vary. When reviewing several companies, look carefully at the benefits they offer.

Tips: checking out an agent

Many people buy health insurance from agents or companies. Agents may represent only one or a number of companies. Companies can sell their policies by mail, the Internet or over the phone.

Agents earn a commission on your business and should do more than just sell you a policy. They should also answer your questions.

If you need additional information, contact your agent or the company. You are the customer, and they should respond to you.

Never deal with an unlicensed agent. Ask to see his or her license. You can check on an agent's licensed status by calling the Insurance Consumer Hotline at 1-800-562-6900.

Never let an insurance agent or broker pressure you. You have the right to look at any policy before you buy it. Never buy because of a threat that "this coverage won't be available tomorrow." Report any improper behavior to the Insurance Commissioner's investigators by calling 1-800-562-6900. You can also ask if an agent has received any complaints.

Never buy an insurance policy you do not understand. Ask to see the benefits explained in writing in simple terms. Keep that piece of paper with the policy after you buy it.

If you need a translator to talk to your agent or company, arrange for an adult translator to accompany you.

Never give any insurance representative money or a check without getting a receipt.

Never give out your bank account or Social Security information over the phone.

Tips: checking out an insurance company

Before you buy health coverage, find out about the company selling the plan. Here are key factors to consider:

Customer service. Find out how the company services its members. Does the company have a toll-free customer service number? Do they answer it without a long wait?

Complaint history. Does the company have a high number of consumer complaints? Check with our Insurance Consumer Hotline at 1-800-562-6900.

Licensing status. Make sure the insurance company is licensed to do business in Washington state. Call our Insurance Consumer Hotline to check a company's status at 1-800-562-6900 or visit our Web site at www.insurance.wa.gov.

Financial stability. Financial stability helps ensure that a company can pay its claims. In addition, Washington state law establishes requirements that each company must follow. The Office of the Insurance Commissioner (OIC) continually monitors insurers to make sure they are financially stable. Independent organizations also rate the financial stability of insurance companies. Check your public library's reference desk for published ratings.

Questions to ask:

What does the plan pay for and what does it exclude? Look for preventive care, immunizations, well-baby care, substance abuse, organ transplants, durable medical equipment, alternative or chiropractic care.

Does the plan have mental health benefits?

Will the plan pay for long-term physical therapy?

How much do I have to pay when I receive health care services, or how much is the copayment or deductible? How often do I have to pay the copayment or deductible (per year, per occurrence)?

Are there limits on how much I must pay for health care services I receive (out-of-pocket maximums)? Are there maximums per year, per occurrence?

Are there limits on the number of times I may receive a service (lifetime maximums, daily or annual benefit caps)?

Does the company have a high number of consumer complaints?

What happens when I call the company's consumer complaint number? How long does it take to reach a real person?

Will the plan pay for prescriptions? If so, what is the maximum benefit?

Are my prescriptions on the formulary (list of approved drugs)?

Is my favorite doctor or other health care professional part of the company's network?

Can I choose my Primary Care Provider (PCP)? If I don't like him or her, what options will I have?

How will I get access to specialists?

What does the company consider as urgent and emergency care?

What treatments does the company consider "experimental" and as a result do not cover?

How does the company coordinate benefits with other plans?

What options do I have if I disagree with the treatment plan?

Complementary and alternative providers

Washington state law requires state-regulated insurers to cover services provided by all of the state's licensed categories of health care providers including, but not limited to:

- ✓ chiropractors
- ✓ medical doctors
- ✓ acupuncturists
- ✓ naturopaths
- ✓ physician assistants
- ✓ registered nurses
- ✓ podiatrists
- ✓ nurse midwives
- ✓ massage therapists

Most health care plans restrict enrollees to providers in their own network, and may require you to visit your primary care provider for a referral.

Insurance companies are required to provide adequate networks that contain every category of provider so you have the full range of options the law requires. Also, your plan must cover your condition, and its treatment must fall within a provider's practice.

This law applies to all state-regulated plans. It does not apply to self-funded employer plans or union trusts, which are exempt from state regulation under federal law. **If you're not sure what type of plan you have, call our Insurance Consumer Hotline at 1-800-562-6900.**

"Free Look"

When you receive your new policy, read it carefully.

Every individual health care insurance policy sold in the state of Washington has a 10-day "Free Look" period.

If you are not satisfied for any reason, you may return the policy within 10 days after you receive it to the company or agent. They will void the policy and provide you with a full refund of your premium.

Keep your previous coverage until you have reviewed your new policy to ensure continuous coverage.

Information on the "Free Look" period is printed or attached to the face sheet of your policy.

Filing claims

Things to do before you file a claim:

Review your policy or employee booklet carefully to make sure the plan covers the service in question. If you have any reason to think a health care service may not be covered, or that your company disagrees with your understanding of the policy, talk it over first with your provider and with the insurance company. Resolving questions first can prevent problems later.

You should never assume your plan will cover a treatment or service. Follow your plan's rules, including pre-certification requirements and use of network providers. Your provider may require you to make a copayment or pay your coinsurance at the time of visit.

Fill out any claim forms the provider or insurance company gives you. Be sure to include your policy number and other identifying information.

How to submit a claim yourself:

- ✓ Find out if your provider submits the claim for you or if you need to do it.
- ✓ If you need to do it, review the claim information to make sure it is complete and correct.
- ✓ File the claim as soon as you get the bill from the provider.
- ✓ Send it to the correct address.
- ✓ Keep a copy for your reference.
- ✓ Wait for your company's statement before you pay your provider directly.
- ✓ Allow reasonable time for the company to process your claim. The company must inform you if it needs any additional information to complete the claim. Sometimes, it will request additional information directly from the providers; in other cases, it will return the claim form to you to get more information.

If the insurance company denies your claim:

- ✓ They should state the reason on your explanation of benefits.
- ✓ If you disagree with the reason for denial, check your policy or employee booklet for the company's appeal procedures.
- ✓ The company should answer procedural questions about appeals over the phone. Call the company's assistance line (the phone number should be listed on your statement).
- ✓ Submit your appeal in writing. The company may require information from your doctor.

Getting help

As a health insurance consumer, you should understand what your rights are and how to exercise them.

Patient Bill of Rights

The Washington State Legislature passed the Patient Bill of Rights in 2000. This ensures that patients covered by health plans receive quality care, timely access to health care, and an adequate choice of health care providers. It outlines procedures to ensure patients:

- ✓ Make health care decisions based on appropriate medical standards.
- ✓ Have better access to information about their health insurance plans.
- ✓ Have the right to a second opinion.
- ✓ Have access to a quick and impartial process for appealing denials of coverage.
- ✓ Have the right to independent third-party reviews of denials.
- ✓ Are protected from unneeded invasions of their privacy.
- ✓ Can seek remedy for damages that result when managed care insurers withhold or deny appropriate care.

This law took effect July 1, 2001, or on the date of the insurance policy's renewal. For more information, see the Patient Bill of Rights fact sheet at www.insurance.wa.gov or call our Insurance Consumer Hotline at 1-800-562-6900 to request a copy.

Other rights

Employer plans: If your plan is a "self-funded" plan offered by an employer, or by a union trust under a union contract, the federal government regulates your plan. You may file a complaint with the U.S. Department of Labor (DOL) Employee Benefits Security Administration toll free at 1-866-444-3272. DOL may investigate your complaint. In some disputes, DOL may suggest personal legal advice as your best option.

Government/church plans: If the plan is self-funded, but offered through a government or church employer, follow the appeals procedures outlined in your benefit booklet and other plan documents. In most cases, final responsibility for resolving these disputes rests with the governing body of the employer sponsoring the plan, such as a school board.

The disabled: If you have a disability, you may have special protections available under the Americans with Disabilities Act (ADA) that apply specifically to self-funded coverage. You can reach the ADA Technical Assistance Center at 1-800-949-4232 or the U.S. Department of Justice at 1-800-514-0301 (voice) or 1-800-514-0383 (TDD).

Filing a complaint with the Office of the Insurance Commissioner

If you're unable to resolve a dispute with your company or agent and still believe you have a valid case, contact the Insurance Consumer Hotline at 1-800-562-6900. We investigate consumer complaints at no cost. To speed processing of your inquiry or complaint:

Call the Insurance Consumer Hotline first to talk to a health insurance expert about your problem. You also can ask us to mail you a complaint form or you can access the form online at www.insurance.wa.gov.

Use the form to briefly state your case, but provide complete information. Be sure to include:

- ✓ Name of your insurance company
- ✓ Policy number
- ✓ Name of the agent or adjuster
- ✓ Name of your employer, if the plan is offered through your employer

Also, make sure you sign the medical release on the back of the form.

Include photocopies of any documentation that supports your case. (Do not send original documents.)

Provide the details of your dispute, including who you talked to and what they told you.

We will investigate your complaint and inform you of what happens. If the company has made a mistake, we will work on your behalf to correct the situation.

Call our Insurance Consumer Hotline

1-800-562-6900

It's fast and it's free!

Section 3

Low cost health coverage options

In general, these programs help people who cannot afford insurance in the individual market. Some programs are designed to help people who are disabled or who have limited incomes and assets. Often, people are not aware they qualify for these programs. Following are several health coverage programs for individuals and families, children, pregnant women and infants, and veterans and active military personnel.

Individuals and families

Alien Emergency Medical (AEM)

AEM is a program for non-citizen aliens with a serious medical condition(s). It helps you pay for medical treatment and bills. Non-citizens, non-qualified aliens, visitors, and qualified aliens can apply for it. You must meet income and assets requirements. For information, call the Department of Social and Health Services at (DSHS) at 1-800-865-7801 or visit www.dshs.wa.gov.

Basic Health

The state of Washington offers Basic Health (BH) to Washington state limited income residents. Individuals who are eligible for Medicare, institutionalized at the time of enrollment, and those attending school full time in the U.S. on a student visa are NOT eligible for BH.

Private insurance companies administer BH. It is a comprehensive health plan that covers:

- ✓ prescription drugs
- ✓ maternity
- ✓ preventive care
- ✓ major medical costs

However, BH does not cover:

- ✓ eye exams
- ✓ dental and hearing exams
- ✓ artificial limbs or medical equipment (such as wheelchairs or back braces)
- ✓ Physical therapy and chiropractic care is limited to specific circumstances

BH requires you to use a network of providers in your area. Besides paying a monthly premium, you must meet the $150 deductible each year and make a small copayment each time you visit your health care provider. On some services, BH also requires a 20 percent coinsurance payment.

People enrolled in BH pay on a sliding scale, with premiums based on income, age, family size, county of residence, and choice of carrier.

BH may be available for children. For more information, see “Basic Health Plus” on page 13.

You can obtain benefits, rates, and other details by calling 1-800-660-9840, or visit BH at www.basichealth.hca.wa.gov.

Breast and Cervical Cancer Treatment Coverage

This program provides medical coverage for women with breast or cervical cancer, or a related pre-cancerous condition. Approved providers must screen you, and you must meet income and assets requirements. There are no citizenship requirements. For more information, call the Breast and Cervical Program toll free at 1-888-551-3994 or your local health department. To find your local health department, look under “county” in the blue government listing pages of your phone book.

For more information on income levels, read the federal poverty level chart. If you need a copy, visit the Web at http://www.insurance.wa.gov/publications/consumer/FINAL_FPL_chart-05-05-06.pdf or call the SHIBA HelpLine at 1-800-562-6900.

Community Health Clinics

These clinics offer health services for the entire community on a sliding-scale fee. For information, call the Association of Community and Migrant Health Centers at 360-786-9722 or visit www.bphc.hrsa.gov.

Early Intervention Program

If you have HIV, this program can provide financial help for medical and dental coverage, and prescription drugs. If you are eligible, the program also provides help with paying insurance premiums. For information, call the Washington State Department of Health at 1-800-272-2437.

Evergreen Health Insurance Program (EHIP)

If you have AIDS, this program may help you pay for your insurance premiums. For information, call EHIP at 1-800-945-4256.

General Assistance Unemployable (GAU)

GAU provides cash and medical benefits to people who are physically and/or mentally incapacitated and unemployable for 90 days from the date of application. Medical care is limited. Immigrants can also apply for this program. You must meet disability, income, and assets requirements. For information, call DSHS at 1-800-865-7801 or visit www.dshs.wa.gov.

Health Care for Workers with Disability

This program allows disabled people who are working to buy medical coverage through a monthly premium based on their income. You must meet income requirements, however, there are no assets limits. You must also meet disability, employment status, and age (16-64) requirements. There are no citizenship requirements. For more information, call DSHS at 1-800-865-7801, or visit www.dshs.wa.gov.

Hospital Charity Care

Some hospitals offer a program for people who cannot pay their medical bills. They provide either free care or at-reduced prices to limited income people. Also, many hospitals offer financial assistance programs. You must meet income requirements. For more information, talk to the hospital billing office staff.

Indian Health Services (IHS)

This is a federal health program for American Indians and Alaska natives. IHS also may provide services to Indians of Canadian or Mexican origin, or to non-Indian women pregnant with an eligible Indian's child. For more information, call IHS at 503-326-2020 or contact your local tribe/clinic.

Medicaid

Medicaid is a publicly funded program that provides health insurance to specific categories of people who meet financial eligibility requirements. You must meet citizenship requirements.

The Washington State Department of Social and Health Services (DSHS) offers Medicaid programs through its local Community Service Offices.

Medicaid is a complex system of programs, requirements, and benefits. There are many different Medicaid programs available for specific eligibility groups. In Washington, those groups include:

✓ pregnant women
✓ infants
✓ children
✓ low-income families
✓ disabled individuals
✓ blind people
✓ people over age 65
✓ aliens and refugees

Due to the variety of eligibility requirements for different programs, DSHS recommends that you review your eligibility online at http://fortress.wa.gov/dshs/maa/eligibility/index.html. You can also talk to a customer service representative. Call DSHS at 1-800-562-3022 to find the Community Service Office nearest you.

Medicare

Medicare is a health insurance program for people age 65 and older, some younger people with disabilities, and people with End Stage Renal Disease (ESRD) or kidney failure. It helps you pay for many health care expenses but not all of them. You must meet citizenship/immigration status requirements. If you have End Stage Renal Disease (ESRD), there are no residency, citizenship, or legal status requirements. For more information, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board, call 1-800-808-0772.

Medicare Savings Programs

These are programs for people with limited income and assets to help pay for Medicare premiums, deductibles, and coinsurance. You must meet income and asset requirements. For more information, call DSHS at 1-800-865-7801 or visit www.dshs.wa.gov. You can also call the Medical Assistance HelpLine at 1-800-562-3022 or visit https://wws2.wa.gov/dshs/onlinecso/findservice.asp.

Take Charge

This program offers free family planning and birth control methods for one year for men and women. You must meet income, and citizenship or alien status requirements. For more information, call the Family Planning Hotline at 1-800-770-4334.

Tuberculosis care

If you have Tuberculosis, contact your local health department. To find the nearest office, visit http://www.doh.wa.gov/LHJMap/LHJMap.htm. You can also look under "county" in the blue government listing pages of your phone book.

Children

Basic Health Plus

Basic Health Plus is a Medicaid program for children in low-income households. There are no copayments for services and no monthly premiums. DSHS pays the cost of coverage. It offers added benefits and services for children, including vision and dental benefits, and transportation to medical services. If you are on Basic Health, your children may be eligible for Basic Health Plus. They must be under age 19, a U.S. citizen, or legal resident who arrived in the U.S. before Aug. 22, 1996. You can enroll children not living in your household in Basic Health (see page 11), but not Basic Health Plus. For more information, call 1-800-660-9840, or visit the Basic Health Web site at www.basichealth.hca.wa.gov.

Children's Health Insurance Program (CHIP)

Children's Health Insurance Program (CHIP) is a federal and state program that covers children under age 19 in families with limited income. Many children who don't qualify for Basic Health are eligible for CHIP. A family must meet income limits for children to qualify for CHIP. These income limits represent gross monthly household income minus childcare and other approved deductions.

When you apply for CHIP, DSHS considers the children for Medicaid first. If the children are not eligible for Medicaid because of income, DSHS will then check to see if the family income fits within the CHIP income guidelines. If children are eligible for Medicaid, they are not eligible for CHIP.

The Children's Health Program (CHP)

This program provides medical coverage to non-citizen children, including visitors or students

from another country, undocumented children, and qualified alien children under age 18 in limited-income families. You must meet income requirements.

Children's medical programs have no asset limits. Remember, you must apply for children's medical programs and Alien Emergency Medical (see page 11) at the same time.

For more information about children's medical programs, visit http://fortress.wa.gov/dshs/maa/chip or call toll free at 1-877-543-7669.

Pregnant women and infants

Pregnancy Medical

This program offers medical coverage for pregnant women regardless of their citizenship, including undocumented women. You must meet income requirements, but there are no assets limits. Your newborn baby automatically receives full medical benefits for the first year. Call DSHS at 1-800-562-3022 to find the Community Service Office nearest you.

Active military and veterans

TRICARE military insurance

This insurance covers:

- ✓ active duty and retired service members
- ✓ some reserve members
- ✓ spouses and unmarried children
- ✓ widows or widowers
- ✓ unmarried children of deceased active duty or retired service members

For more information, call TRICARE toll free at 1-888-TRIWEST (1-888-874-9378) or visit www.tricare.osd.mil.

Veterans' Assistance

If you are a veteran, you may be entitled to care and prescription drug coverage through a Department of Veteran Affairs (VA) medical facility. You may be eligible for assistance if you served at least 180 days of active duty and received an honorable or general discharge. For more information, call the VA Health Benefits Service Center at 1-877-222-VETS.

Resources

Washington State Office of the Insurance Commissioner

For publications and help with questions and concerns about all types of insurance:
Insurance Consumer Hotline: 1-800-562-6900
or www.insurance.wa.gov

For education and assistance with health insurance and health care access issues, publications, and referral to a local counseling site:
SHIBA HelpLine: 1-800-562-6900 or
www.insurance.wa.gov/consumers/shiba/default.asp

Centers for Medicare and Medicaid Services (CMS)

Medicare Hotline
(800) MEDICARE: 1-800-633-4227
Local customer service: **(206) 615-2345**
Local service for Medicare Managed Care:
(206) 615-2351 or www.medicare.gov

Washington State Health Care Authority

Public Employees Benefit Board (PEBB)
www.pebb.hca.wa.gov
Employee customer service: 1-800-700-1555
Retiree customer service: 1-800-200-1004
Basic Health customer service: 1-800-660-9840
or www.basichealth.hca.wa.gov

Federal Department of Health and Human Services

National Elder Care Locator Service:
1-800-677-1116 or www.eldercare.gov

Federal Department of Labor - Employee Benefits Security Administration

Benefit advisors and publication hotline:
1-866-444-3272 or www.dol.gov

Washington State Health Insurance Pool (WSHIP)

Customer service: 1-800-877-5187
or www.wship.org

Federal Social Security Administration

Customer service: 1-800-772-1213
or www.socialsecurity.gov

Need more help?

Call our Insurance Consumer Hotline!

1-800-562-6900

Our professional consumer advocates enforce insurance law and can investigate complaints against insurance companies and agents on your behalf.

We also offer individual counseling and group education on health care issues in your communities. Our highly trained Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine volunteers can help you understand your rights and options regarding health care coverage, prescription drugs, government programs, and more.

Call our Insurance Consumer Hotline

1-800-562-6900

SHP106FR-2000-OIC-Consumer Guide, Health Care-EN-Rev. 10/06